

		FOR OFF USE					

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2005  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2005)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0040659</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Miller Health Care Center</u>		<b>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</b>	
<b>Address:</b> <u>1601 Butterfield Trail</u> <u>Kankakee</u> <u>60901</u>		<b>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</b>	
<b>County:</b> <u>Kankakee</u>			
<b>Telephone Number:</b> <u>(815)936-6500</u> <b>Fax #</b> <u>(815)936-6502</u>			
<b>IDPA ID Number:</b> <u>363670744001</u>			
<b>Date of Initial License for Current Owners:</b> _____			
<b>Type of Ownership:</b>			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		<input type="checkbox"/> PROPRIETARY	
<input checked="" type="checkbox"/> Charitable Corp.		<input type="checkbox"/> Individual	
<input type="checkbox"/> Trust		<input type="checkbox"/> State	
<b>IRS Exemption Code</b> _____		<input type="checkbox"/> Partnership	
		<input type="checkbox"/> County	
		<input type="checkbox"/> Corporation	
		<input type="checkbox"/> Other _____	
		<input type="checkbox"/> "Sub-S" Corp.	
		<input type="checkbox"/> Limited Liability Co.	
		<input type="checkbox"/> Trust	
		<input type="checkbox"/> Other _____	
<b>In the event there are further questions about this report, please contact:</b>			
<b>Name:</b> <u>Patt Marlinghaus</u>		<b>Telephone Number:</b> <u>(815)935-7256 x3544</u>	

<b>Officer or Administrator of Provider</b>	(Signed) _____	<u>03/30/2006</u>
	(Type or Print Name) <u>Bill W. Douglas</u>	(Date)
	(Title) <u>Chief Financial Officer and Treasurer</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date)
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) <u>( )</u>	Fax # ( )
	<b>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</b>	

Facility Name & ID Number Miller Health Care Center

# 0040659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	70	Skilled (SNF)	70	25,550	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		12,583	7,475	20,058	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	2,232	15,316		17,548	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,232	27,899	7,475	37,606	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.86%

D. How many bed-hold days during this year were paid by the Department?

17 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

vending machines and guest/employee meals

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

☐

NO

☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started 02/13/1995

J. Was the facility purchased or leased after January 1, 1978?

YES

☐

Date

NO

☒

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number

of beds certified

28

and days of care provided

7,475

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH\*

☐

CASH\*

☐

Is your fiscal year identical to your tax year?

YES

☐

NO

☐

Tax Year: 12/31/2005

Fiscal Year: 12/31/2005

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name & ID Number      Miller Health Care Center      #      0040659      Report Period Beginning:      01/01/2005      Ending:      12/31/2005

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	288,196	123,668	19,731	431,595	(318)	431,277	(13,144)	418,133			1
2	Food Purchase		229,105		229,105		229,105		229,105			2
3	Housekeeping	111,802	30,707	53,290	195,799	(53,025)	142,774		142,774			3
4	Laundry					53,025	53,025	(15,440)	37,585			4
5	Heat and Other Utilities			128,796	128,796		128,796		128,796			5
6	Maintenance	64,961	2,785	78,412	146,158		146,158		146,158			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	464,959	386,265	280,229	1,131,453	(318)	1,131,135	(28,584)	1,102,551			8
	<b>B. Health Care and Programs</b>											
9	Medical Director					319	319		319			9
10	Nursing and Medical Records	2,299,506	686,282	39,819	3,025,607	(4,379)	3,021,228	8,477	3,029,705			10
10a	Therapy		320	328,397	328,717	(309)	328,408	33,309	361,717			10a
11	Activities	82,392	3,853	7,090	93,335	(197)	93,138		93,138			11
12	Social Services	37,993	450		38,443		38,443		38,443			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,419,891	690,905	375,306	3,486,102	(4,566)	3,481,536	41,786	3,523,322			16
	<b>C. General Administration</b>											
17	Administrative	274,587			274,587		274,587	17,938	292,525			17
18	Directors Fees											18
19	Professional Services			1,550	1,550	(319)	1,231		1,231			19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses		14,243	238,107	252,350	(7,782)	244,568	(44,831)	199,737			21
22	Employee Benefits & Payroll Taxes			1,019,997	1,019,997		1,019,997		1,019,997			22
23	Inservice Training & Education											23
24	Travel and Seminar					12,985	12,985		12,985			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			31,360	31,360		31,360		31,360			26
27	Other (specify):* <b>Admitting</b>	34,641	103	663	35,407		35,407		35,407			27
28	<b>TOTAL General Administration</b>	309,228	14,346	1,291,677	1,615,251	4,884	1,620,135	(26,893)	1,593,242			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,194,078	1,091,516	1,947,212	6,232,806		6,232,806	(13,691)	6,219,115			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name & ID Number Miller Health Care Center #0040659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			387,844	387,844		387,844		387,844			30
31	Amortization of Pre-Op. & Org.			4,201	4,201		4,201		4,201			31
32	Interest			133,548	133,548		133,548	(26,804)	106,744			32
33	Real Estate Taxes				142,148		142,148		142,148			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			26,500	26,500		26,500		26,500			36
37	<b>TOTAL Ownership</b>			552,093	694,241		694,241	(26,804)	667,437			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			18,799	18,799		18,799	(18,799)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			84,499	84,499		84,499	(18,799)	65,700			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,194,078	1,091,516	2,583,804	7,011,546		7,011,546	(59,294)	6,952,252			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,144)	1		4
5	Telephone, TV & Radio in Resident Rooms	(3,875)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(15,440)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(26,804)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,956)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (100,219)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,255,284		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,255,284		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ 1,155,065		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops		X	(18,799)	40	40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ (18,799)		47

STATE OF ILLINOIS

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Miller Health Care Center

ID#0040659

Report Period Beginning:01/01/2005

Ending:12/31/2005

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Miller Health Care Center

# 0040659

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(13,144)	0	0	0	0	0	0	0	0	0	0	(13,144)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(15,440)	0	0	0	0	0	0	0	0	0	0	(15,440)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(28,584)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(28,584)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(44,831)	0	0	0	0	0	0	0	0	0	0	(44,831)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(44,831)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(44,831)</b>	<b>28</b>
	<b>TOTAL Operating Expense</b>													
29	<b>(sum of lines 8,16 &amp; 28)</b>	<b>(73,415)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(73,415)</b>	<b>29</b>





VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Riverside Health System	100			Riverside Medical Cen	Kankakee, IL	Hospital
				Riverside Senior Livin	Kankakee, IL	Senior Living
				Oakside Corporation	Kankakee, IL	DME/HHA/Retail P

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Linen	\$ 52,743	Riverside Medical Center		\$ 52,743	\$	1
2	V		DON salary	77,831	Riverside Medical Center		77,831		2
3	V		Lab services	19,231	Riverside Medical Center		19,231		3
4	V		Ambulance services	2,276	Riverside Medical Center		2,276		4
5	V		Radiology services	6,812	Riverside Medical Center		6,812		5
6	V		Infusion services	5,359	Riverside Medical Center		5,359		6
7	V		M/S Supplies and drugs (Oakside)	1,151	Oakside Corporation		1,151		7
8	V		M/S Supplies and drugs (Riverside)	20,914	Riverside Medical Center		20,914		8
9	V		Administrator salary	164,700	Riverside Medical Center		164,700		9
10	V		Administrative services	12,000	Riverside Medical Center		1,207,562	1,195,562	10
11	V		Employee drug testing	4,800	Riverside Medical Center		4,800		11
12	V		Benefits	134,664	Riverside Medical Center		194,387	59,723	12
13	V		Respiratory/Therapy services	305,838	Riverside Medical Center		305,838		13
14	Total			\$ 808,319			\$ 2,063,604	\$ * 1,255,285	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Riverside Medical Center  
Street Address 350 North Wall Street  
City / State / Zip Code Kankakee, IL 60901  
Phone Number ( 815)935-7256  
Fax Number ( 815)935-8160

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Administrative services	Cost	143,211,216	2	\$ 24,664,523	\$ 64,960,144	7,011,543	\$ 1,207,562	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 24,664,523	\$ 64,960,144		\$ 1,207,562	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bond - 1994		X	Building construction		1994	\$ 5,152,000	\$			\$ 97,627	1	
2	Bond - 2000		X	Building addition		2000	640,366				4,763	2	
3	Bond - 2004		X	Partial refinancing of 2000 bonds		2004	757,371				31,157	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 6,549,737	\$			\$ 133,548	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 6,549,737	\$			\$ 133,548	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2004 report.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	142,1484
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND   \$   For   Tax Year.   (Attach a copy of the real estate tax appeal board's decision.)</b>				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	142,1487
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000		8	
		2001		9	
		2002		10	
		2003		11	
		2004		12	
				13	FROM R. E. TAX STATEMENT FOR 2004   \$   13
				14	PLUS APPEAL COST FROM LINE 5   \$   14
				15	LESS REFUND FROM LINE 6   \$   15
				16	AMOUNT TO USE FOR RATE CALCULATION \$   16

- NOTES:
1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Miller Health Care Center COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0040659

CONTACT PERSON REGARDING THIS REPORT Patt Marlinghaus

TELEPHONE (815)935-7256 x3544 FAX #: (815)935-8160

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 47,164
- B. General Construction Type: Exterior Brick Frame Number of Stories 1
- C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
List entity name, type of business, square footage, and number of beds/units available (where applicable).

- F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO  
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:   
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Skilled nursing Facility		1991	\$ 886,000	1
2					2
3	TOTALS			\$ 886,000	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1995	1995	\$ 3,542,313	\$ 135,150	12.46883	\$ 135,150	\$	\$ 1,685,163	4
5	10		1999	1999	656,641	38,759	7.28783	38,759		282,469	5
6	10		2001	2001	147,085	14,963	4.499833	14,963		67,331	6
7			2004	2004	94,121	16,011	1.510462	16,011		24,184	7
8			2005	2005	205,826	36,954	1	36,954		36,954	8
	Improvement Type**										
9	Land improvments		1995		63,411	3,459	16.83348	3,459		58,227	9
10	Building service equipment		1995		1,295,587	64,027	10.566	64,027		676,509	10
11	Land improvments - landscaping		1997		4,688	468	8.514957	468		3,985	11
12	Land improvments - walkways		1998		15,388	1,026	7.5	1,026		7,695	12
13	Building - carpeting		1998		2,370		#DIV/0!			2,370	13
14	Land improvments - landscaping and pond decks		1999		25,379	2,537	6.502168	2,537		16,496	14
15	Building - carpeting		2000		3,125	312	10.01603	312		3,125	15
16	Building service equipment - exterior electrical lighting		2000		1,100	61	5.508197	61		336	16
17	Land improvments - landscaping		2001		16,069	1,398	4.5	1,398		6,291	17
18	Building service equipment - HVAC		2001		2,551	128	4.492188	128		575	18
19	Land improvments - courtyard concrete		2002		640	32	3.5	32		112	19
20	Building service equipment -HVAC/water heaters		2002		9,547	1,042	3.5	1,042		3,647	20
21	Building service equipment - HVAC/water heaters		2003		5,003	439	2.498861	439		1,097	21
22	Land improvments - gazebo		2004		510	25	1.52	25		38	22
23	Building service equipment - waterline/sprinkler system revision		2004		8,208	514	1.498054	514		770	23
24	Land improvmenets - asphalt walkway		2005		7,574	473	1	473		473	24
25	Building service equipment - water heater/generator doors/compressor/HV		2005		8,142	324	1	324		324	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$6,115,278	\$318,102		\$318,102	\$	\$2,878,171	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$804,838	\$69,317	\$69,317	\$		\$594,816	71
72	Current Year Purchases	11,720	425	425			425	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$816,558	\$69,742	\$69,742	\$		\$595,241	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$7,817,836	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$387,844	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$387,844	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,473,412	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease
- 
- 

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- 
- \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$
- Description:
- 
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
- Beginning
- Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A C3	3618 hrs	\$ 85,004		\$		3,618	\$ 85,004	1
2	Licensed Speech and Language Development Therapist	L10A C3	645 hrs	18,208				645	18,208	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A C3	9043 hrs	193,127				9,043	193,127	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Respiratory therapy	L10A C3	1423	32,378				1,423	32,378	13
14	TOTAL			\$ 328,717		\$	\$	14,729	\$ 328,717	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 720,789	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 268,265 )	1,065,961		3
4	Supply Inventory (priced at )	374		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	140,441		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Medicare	(3,000)		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,924,565	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	133,659		13
14	Buildings, at Historical Cost	4,649,111		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,146,697		16
17	Accumulated Depreciation (book methods)	(3,453,797)		17
18	Deferred Charges	38,102		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Due from RPT	4,057,905		22
23	Other(specify): Trustee-held assets	87,927		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 7,659,604	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 9,584,169	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 95,637	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	223,243		29
30	Accrued Salaries Payable	439,731		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,186		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Accrued expenses	35,148		36
37	Deferred revenue	11,055		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 829,001	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,247,617		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	Due to RPT	163,941		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 4,411,558	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 5,240,559	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 4,343,610	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 9,584,169	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,997,805	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,997,805	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	345,805	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 345,805	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,343,610	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,021,549	1
2	Discounts and Allowances for all Levels	(466,887)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,554,663	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,082,240	6
7	Oxygen	6,985	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,089,225	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	19,898	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	583,387	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,911	19
20	Radiology and X-Ray	22,711	20
21	Other Medical Services	14,840	21
22	Laundry	15,440	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 688,188	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	25,270	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25,270	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,357,346	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	651,544	31
32	Health Care	4,276,600	32
33	General Administration	1,465,614	33
	B. Capital Expense		
34	Ownership	552,083	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,011,541	40
41	Income before Income Taxes (line 30 minus line 40)**	345,805	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 345,805	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,804	2,036	\$ 79,697	\$ 39.14	1
2	Assistant Director of Nursing	1,786	2,108	52,137	24.73	2
3	Registered Nurses	21,061	22,856	578,577	25.31	3
4	Licensed Practical Nurses	30,362	33,873	594,626	17.55	4
5	CNAs & Orderlies	76,015	83,236	844,908	10.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,780	1,984	29,552	14.90	9
10	Activity Assistants	4,667	5,194	51,383	9.89	10
11	Social Service Workers	1,832	2,030	37,199	18.32	11
12	Dietician			65,617		12
13	Food Service Supervisor	3,949	4,331		0.00	13
14	Head Cook		21,298	183,525	8.62	14
15	Cook Helpers/Assistants	19,469	5,151	36,496	7.09	15
16	Dishwashers	4,825	2,247	61,913	27.55	16
17	Maintenance Workers	1,998	12,776	110,288	8.63	17
18	Housekeepers	11,701				18
19	Laundry		2,036	184,640	90.69	19
20	Administrator	1,767				20
21	Assistant Administrator		4,352	106,743	24.53	21
22	Other Administrative	3,891	1,546	25,715	16.63	22
23	Office Manager	1,390	6,088	62,520	10.27	23
24	Clerical	5,663				24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,397	2,022	52,633	26.03	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Admission Co-ord/	1,962	2,268	35,909	15.83	33
34	TOTAL (lines 1 - 33)	197,319	217,432	\$ 3,194,078 *	\$ 14.69	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,231		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 1,231		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

**Facility Name & ID Number** Miller Health Care Center

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Judy Amiano	Administrtrtor	0	\$ 164,700	Workers' Compensation Insurance		\$ 32,543	IDPH License Fee		\$		
				Unemployment Compensation Insurance		4,707	Advertising: Employee Recruitment				
				FICA Taxes		233,177	Health Care Worker Background Check				
				Employee Health Insurance		613,325	(Indicate # of checks performed )				
				Employee Meals							
				Illinois Municipal Retirement Fund (IMRF)*							
				Pension		90,164					
				Life insurance		13,980					
				Disability insurance		8,111					
				Dental insurance		12,835					
				Accrued vacation		12,165					
				Professional liability insurance		24,111					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 1,045,118	TOTAL (agree to Schedule V, line 22, col.8)				
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Description			Amount	Description	Line #	Amount	Description		Amount		
			\$			\$	Out-of-State Travel		\$		
							In-State Travel				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Seminar Expense				
C. Professional Services							Subclass 9200		12,986		
Vendor/Payee	Type		Amount								
Enloe Drugs	Pharmacy consultation		\$ 1,231								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)						\$	Entertainment Expense		(		
			\$ 1,231				(agree to Sch. V, line 24, col. 8)				
				TOTAL			TOTAL		\$ 12,986		

**\* Attach copy of IMRF notifications**

**\*\*See instructions.**

**(See instructions.)**

[illegible]

Facility Name &amp; ID Number Miller Health Care Center

# 0040659

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services Network \$13,601
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 9 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,080 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
Not applicable
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 13,144
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
**g. Does the facility transport residents to and from day training?** No  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KMPG LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Incomplete at cost report due date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.